EPARTMENT OF HEALTH AND HUMAN SERVICES
EALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **02-010**

2. STATE: **Alaska**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 USC 1396b / 42 CFR 447.272

7. FEDERAL BUDGET IMPACT:
a. FFY 03 $ 0.00
b. FFY 04 $ 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Section XIV, Pages 23 and 24

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Section XIV, Pages 23 and 24, 24-A

10. SUBJECT OF AMENDMENT:
Public Hospital definition and payment frequency to facility clarified.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Does not wish to comment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Bob Labbe

14. TITLE:
Director

15. DATE SUBMITTED:
September 12, 2002

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 16, 2002

18. DATE APPROVED:
November 22, 2002

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:
Charlene Brown for Smith

21. TYPED NAME:
Charlene Brown

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

commissioner concerning exceptional relief may request an administrative hearing to the commissioner of the department.

XIII. Public Process

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

XIV. Proportionate Share Incentive Payments for Public Hospitals.

1. The department recognizes that many public hospitals provide basic support for community and regional health care to clients who would otherwise be unable to readily access needed inpatient hospital service. To ensure continued access, proportionate share incentive payments (Hospital Pro-Share payments) are provided to in-State public hospitals. At least annually, the department will advise all such hospitals to formally request participation in the Hospital Pro-Share payment program.

2. A public hospital is a non-state government owned or operated facility.

3. The state determines a reasonable estimate of what Medicare would have paid to public hospitals by calculating the Medicare upper payment limit (UPL). The Medicare UPL is the result of inflating the TEFRA inpatient rate forward from the 1982 base year, using allowable adjustments as set out in public law, the Federal register, notices from the Centers for Medicare and Medicaid Services, hearing decisions, or similar authoritative notices. For hospitals built after 1982, the first full year of operation is the hospital's base year.

   The TEFRA inpatient rate is expressed as a discharge rate and Medicaid estimated payments are based on per diem rates. Medicaid inpatient days are divided by the average length of stay to obtain the Medicaid discharge rate. Medicaid discharges are then multiplied by the inflated TEFRA inpatient rate, resulting in the Medicare UPL. Inpatient rates and discharges are based on the most recent Medicare cost reports.

   Total estimated Medicaid payments for the current year are obtained by multiplying the current facility Medicaid inpatient rate by the number of Medicaid inpatient days reported on the most recent Medicare cost report. This total is then subtracted from the UPL to determine the difference, if any, between the UPL and the estimated Medicaid payments. The most recent complete Medicare cost report data are adjusted to take into consideration any facility fiscal year offset with the state fiscal year, amended information submitted by the facility, and capital costs.

   The public hospital facility-specific differences between UPL and estimated Medicaid payments are added together to calculate the statewide total for additional payments to all publicly owned hospitals for inpatient services. This aggregate difference represents the total available in the Hospital Pro-Share Program. An adjustment is made to the statewide total UPL to account for the effect of Medicare disproportionate share payments and Medicare graduate medical education payments.

4. Hospital Pro-Share payments will be paid annually on or before September 30th during each federal fiscal year. The state may make one additional payment per year, if needed to reconcile the federal fiscal year with state fiscal year expenditures. State fiscal year payments require money from two Federal fiscal years. The second payment may be held until the next Federal fiscal year monies are available. Payments are based on projections of completed years, therefore no further adjustments are made for over-or under-payments.

   The State recognizes that occupancy is the key measure in determining the payment for each participating hospital. Specifically, a hospital with a low occupancy level tends to be more fiscally vulnerable compared to a hospital with a high occupancy level. Each participating hospital will be assigned an occupancy weight as follows:

Occupancy Level	Occupancy Weight
40 percent or more	1.00
30 – 39 percent	1.05
20 – 29 percent	1.10
10 – 19 percent	1.15
less than 10 percent	1.20

   The occupancy level used to determine a hospital's occupancy weight will be the percent that results from dividing the total number of patient days by the total number of available bed days disclosed in the Medicare cost report for the hospital's fiscal year ending 24 months before the payment. These payments, when combined with other non-DSH medical assistance payments, will not, in aggregate, exceed a reasonable estimate of what Medicare would have paid for similar services.

5. Hospital Pro-Share payments will not be subject to settlement (payment at the lower of costs or rate), or to state law governing payment rates AS 47.07.070 or regulations in 7 AAC 43.670 – 7 AAC 43.676 and 7 AAC 43.678 – 7AAC 43.709.